VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: SAIFULLAH K. NIAZI, M.D.
License No.: 0101-024968

CONSENT ORDER

By Order entered August 29, 2013, the Virginia Board of Medicine ("Board") summarily suspended the license of Saifullah K. Niazi, M.D., to practice medicine and surgery in the Commonwealth of Virginia. Simultaneously, the Board noticed the matter for a formal administrative hearing to address allegations set forth in the Notice of Formal Hearing and Statement of Particulars dated August 29, 2013. On or about January 13, 2014, the Board notified Dr. Niazi of a rescheduled date for the formal hearing of February 21 and 22, 2014. Dr. Niazi, by counsel, requested a continuance of said formal hearing, which the Board granted, continuing this matter generally.

In lieu of proceeding to a formal administrative hearing, the Board and Dr. Niazi, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting Dr. Niazi's license to practice medicine and surgery in Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Board adopts the following findings and conclusions in this matter:

1. Dr. Niazi was issued license number 0101-024968 by the Board to practice medicine in the Commonwealth of Virginia on August 12, 1974. Said license was summarily suspended by Order of the Board entered August 29, 2013.

2. Dr. Niazi violated Sections 54.1-2915.A(3), (11), (12), (13), (16), (17), and (18), 54.1-3303.A and 54.1-3408.A of the Code of Virginia (1950), as amended ("Code"), and 18 VAC 85-20-26(C) and 18 VAC 85-20-29.A(1) of the Board of Medicine's General Regulations, in that, from

approximately 2011 through April 2013, he engaged in practices endangering the health and welfare of his patients (including, without limitation, Patients I-R) when he aided, abetted, and permitted the unauthorized practice of medicine by his unlicensed employees, i.e., current or former Employees U, V, W, X, Y, Z, and AA. Specifically, Dr. Niazi allowed these employees to see, observe, and assess patients independently in their individual offices; to formulate, document, and/or carry over prior diagnoses, assessments and treatment plans; to access, document, and close out progress notes in patients' electronic medical records under his signature without his review or input; and to unilaterally prescribe medications to patients, either electronically or by filling out the paper script and having Dr. Niazi sign it without his having seen the patient during the visit or having seen the patient in only a cursory fashion (e.g., passing them in the hallway, saying "hi" to them in the doorway of his employee's office, chatting with them in his employee's office for 1-2 minutes, etc.), as detailed below:

a. Current Employees W, X, Y, Z, and AA and former Employee U (employed from April to December 2012) reported to a Department of Health Professions' ("DHP") Investigator ("Investigator") in interviews conducted during March and April 2013 that Dr. Niazi did not have a "face-to-face" encounter with every patient who was scheduled to see him or who presented as a walk-in; instead, with Dr. Niazi's knowledge and at his behest, these unlicensed employees have independently seen, assessed, and prescribed to such patients as follows:

i. Employee W, an administrative assistant, informed the Investigator that, prior to recent changes in Dr. Niazi's practice, she and "all the staff" (including office

manager, Employee AA), with his knowledge and approval, would see patients, talk with them, document the record under Dr. Niazi's signature, and send electronic prescriptions or provide patients with paper scripts signed by Dr. Niazi at the employee's request, without his having ever seen the patient or having had only minimal contact with him/her. Employee W also reported that, although Dr. Niazi allegedly instituted changes in his practice recently, there are still instances (at least 1-2 per day) where the aforesaid practices continue and Dr. Niazi does not see patients (or sees them only momentarily) prior to Employees X, Y, and Z electronically prescribing for them or his signing scripts prepared by these employees for patients they have seen.

ii. Employee X, an administrative assistant who started employment in Dr. Niazi's office on or about February 1, 2013, reported to the Investigator that, with Dr. Niazi's knowledge and pursuant to his office practices, she sees approximately 40-50 patients per day by herself, without Dr. Niazi being present or having had only minimal contact with the patient (e.g., standing in her office doorway and chatting with them). During these encounters, Employee X reported that she would pull up and document in the patients' electronic medical records and send e-prescriptions to pharmacies using Dr. Niazi's e-script password based on her unilateral authorization of refills or renewals or, in the case of paper scripts, she would write out the prescription and run it out to Dr. Niazi for his signature, again without his having seen or adequately assessing the patient. Of the patients Employee X sees each day,

she estimates that there are about 10 patients per day who are not seen by Dr. Niazi, meaning the patients do not have any "face-to-face" contact with him.

iii. Employee Y, an unlicensed medical assistant, informed the DHP Investigator that, until very recently, with Dr. Niazi's knowledge and pursuant to his office practices, she routinely saw approximately 20 patients per day in her office and prescribed medications to them, either electronically or via written prescriptions signed by Dr. Niazi, without his seeing the patient at all or only seeing him/her momentarily. Employee Y reported that she would pull up the patient's electronic medical record, review their medications, ask the patient how things were going and whether or not their medications were okay, and document the encounter in the electronic medical record by using pre-programmed checklists and dropdown menus/boxes provided in the program.

iv. Employee Z, Dr. Niazi's receptionist/administrative assistant, informed the DHP Investigator that, until very recently, with Dr. Niazi's knowledge and pursuant to his office practices, she routinely saw approximately 10-15 patients a day and provided them with prescriptions, without Dr. Niazi having seen these patients at all or only having seen them for a minimal period of time (e.g., she would walk some of these patients by Dr. Niazi's office on their way out and he would say "hi" or "how are you" to them). She reports that she would pull up these patients' charts on the electronic medical record, verify their medication list, and ask them how their medications were working, and then sent electronic prescriptions for Schedule V and

VI medications (without any input from Dr. Niazi) or, in the case of Schedule II-IV medications, wrote the prescription out on paper and then took it to Dr. Niazi to sign, without his having seen the patient or only having seen the patient momentarily on his/her way out.

v. Dr. Niazi's office manager, Employee AA, reports that Dr. Niazi has recently initiated a "primary care approach" so that all patients will leave the office feeling as though they have been seen by a physician. Prior to that, Employee AA reports that there may have been instances where Dr. Niazi did not see presenting patients at all and described his approach to patient care as a "lay eyes on patient" approach, e.g., Dr. Niazi would stick his head in the door to say hello to patients while they were being seen by his unlicensed employees, without having a full encounter with them. Employee AA reports that Dr. Niazi has now moved to a system whereby he will "at least consciously stand in the room with the patient and be present for a minute or two."

vi. Former Employee U and Employees W, X, Y, Z, and AA all report, and copies of daily appointment schedules provided by these employees confirm that, during 2012-2013 (after Dr. Niazi become the sole practitioner in the office as of January 1, 2012), approximately 60-100 patients were seen each day, with the appointment log for March 1, 2013 documenting that 179 patients were scheduled that day. Moreover, information that Dr. Niazi provided to the Investigator for the period from August 2012 to May 2013 confirmed these numbers, with the exception of data provided for

March 2013, which indicated that, on average, 128 patients were seen per day in Dr. Niazi's office during that month. However, with office hours from 8:30 a.m. to 5:00 or 6:00 p.m., Monday-Friday, it would be impossible for Dr. Niazi personally to see and examine or adequately assess and treat this many patients in one day, especially in light of the fact that his office manager, Employee AA, reports that patients are seen by Dr. Niazi for 15-30 minute intervals. Further, these employees report that, on a daily or regular basis, they provided Dr. Niazi with lists indicating the patients on the daily appointment schedule that they had seen independently.

b. Former Employee S (employed from October to December 2011) and former Employee T (employed from March to December 2011) each reported to a DHP Investigator that Dr. Niazi failed to actually see or have "face-to-face" encounters with many of the patients who presented to the office during 2011; instead, they reported that Dr. Niazi had his unlicensed staff, including Employee W and former Employee V, see these patients, document in their records, and electronically prescribe for them or have him sign prescriptions that they had filled out for these patients whom Dr. Niazi had not seen during their visits.

c. Numerous patients, to include Patients I, J, K, L, M, N, O, P, Q, and R have reported that Dr. Niazi did not see them at office visits (or saw them only momentarily), but instead they were seen by and provided prescriptions by Dr. Niazi's unlicensed staff (which were transmitted electronically or Dr. Niazi signed paper prescriptions filled out and presented to him by said staff without seeing/assessing the patients). Specifically:

i. On or about March 13, 2013, Patient I, a schizophrenic, presented to Dr. Niazi's office for management and monitoring of her prescribed Clozaril (clozapine, Schedule VI). Although Patient I was seen by and laboratory work was performed by Employee BB, Dr. Niazi did not see Patient I at this visit. Nevertheless, Employee Y sent in an electronic prescription for Clozaril for Patient I to the pharmacy, but prescribed an incorrect dose. When the pharmacist called to question this dosage (and to inform Dr. Niazi that Patient I appeared to be noncompliant with her medication regimen in that she had failed to pick up the Clozaril prescription previously submitted by Dr. Niazi's office on February 13, 2013), Employee Z informed the pharmacist that Patient I had not been seen by Dr. Niazi on March 13, 2013 and the prescription was cancelled. Subsequently, Employee Y called the pharmacist asking why he had questioned the March 13, 2013 prescription and stating that she would talk to Patient I further about her medication. The next day a new e-script for Clozaril was sent to the pharmacy by an employee with a notation to "Please fill today, patient back on track"; however, there is no documented office visit for Patient I on March 14, 2013, nor is there any documentation that Patient I was seen by Dr. Niazi or that she discussed her medication with him (or anyone else in his office) on that date.

ii. Patient J, a 51-year-old male with schizoaffective disorder, bipolar type, and his wife report that, at Patient J's initial office visit on February 13, 2013, he was seen by Employee X, who pulled up and verified his medication list, sent his prescriptions

for Cymbalta, Seroquel (both Schedule VI), and temezapam (Schedule IV) to the pharmacy electronically, and then left the room to obtain Dr. Niazi's signature on a paper script for Xanax. Although Dr. Niazi followed Employee X into her office after signing the Xanax prescription, he did not assess Patient J, but only stuck his head in the doorway and asked if the patient was okay. At Patient J's next visit on March 13, 2013, Patient J and his wife report that he again was seen exclusively by Employee X, who again electronically submitted his prescriptions for Cymbalta, Seroquel, and temezapam and left the office to get Dr. Niazi's signature on the Xanax prescription; this time Patient J and his wife did not encounter Dr. Niazi at all. Subsequently, it was learned from the pharmacy that the electronic prescription for Seroquel submitted by Employee X on March 13, 2013, was written for the incorrect dosage, and Employee X called in a corrected Seroquel prescription for Patient J on or about March 18, 2013.

iii. Patient K, a 39-year-old female with major depressive disorder and anxiety, reports that she did not see Dr. Niazi at her initial office visit on February 4, 2013 or at her next visit on February 26, 2013. Instead, Patient K was seen on those dates by Employee X, who asked her if everything was okay, if her medications were okay, and submitted electronic prescriptions for trazadone (Schedule VI) and fluoxetine. For one of the medications (Xanax), Employee X left the room and obtained Dr. Niazi's signature on a paper script that she then gave to Patient K.

iv. At her first visit to Dr. Niazi's office in January 2013 (exact date unspecified, but note not documented until February 1, 2013), Patient L, a 26-year-old female with anxiety and depression, was seen exclusively by Employee Z. Patient L reports that Employee Z talked with her a few minutes, walked out of the office and returned with a Xanax prescription signed by Dr. Niazi, and electronically submitted the patient's Lexapro (Schedule VI) prescription. When Patient L asked Employee Z if she could see the doctor, especially since she was a new patient, Employee Z told her Dr. Niazi was busy with another patient. Patient L reports that the same scenario was replayed at her second and third office visits on or about March 1 and 29, 2013, although she was seen by Employee X, rather than Z, at each of those visits. Again, Dr. Niazi signed scripts for Xanax that were brought to him and the patient's Lexapro prescriptions were submitted electronically without Dr. Niazi having ever seen her. At her second visit, Patient L reports that she again specifically asked if she could be seen by or talk to a doctor, and she was told "no, you are fine." At the third visit, Patient L reports that, at her request, she saw Dr. Niazi, but all he did was walk into the room, shake her hand, and then left.

v. At her initial office visit on January 31, 2013, Patient M, a 56-year-old female with depression, was seen exclusively by Employee Z. Employee Z required Patient M to submit to a urine drug screen. When Patient M was unable to provide a specimen, allegedly due to bladder problems, Employee Z refused to give the patient her medications or allow her to see Dr. Niazi. Although Patient M reports she

needed and wanted to see a physician that day, she was denied that opportunity. Despite her visit to Dr. Niazi's office on January 13, 2013, there is no documentation of this encounter in the medical record for Patient M.

vi. At his initial office visit on February 12, 2013, Patient N, a 45-year-old male with bipolar disorder and schizophrenia, reports that he did not see Dr. Niazi. Instead, he was seen by Employee X, who gave him prescriptions for #90 Xanax 1 mg (Schedule IV) and #30 fluoxetine 40 mg (Schedule VI).

vii. Patient O, a 48-year-old female with ADHD, reports that at both her initial office visit on February 15, 2013 and her next visit on March 15, 2013, she was not seen by and had no contact with Dr. Niazi, but instead was seen exclusively by Employee X. At both visits, Employee X printed out scripts for Adderall (Schedule II), which Dr. Niazi signed when Employee X brought them to him, yet Dr. Niazi had never seen Patient O.

viii. At her first office visit on February 13, 2013, Patient P, a 44-year-old female with bipolar disorder, was seen and treated exclusively by Employee X. According to Patient P, Employee X pulled up her record on the computer, and asked how she was doing on her medication, and then printed a Xanax prescription, which Employee X brought to Dr. Niazi for his signature. Patient P reports that she wanted to talk to and needed to see a physician at this visit.

ix. Patient Q, a 46-year-old male with major depressive disorder, was seen exclusively by Employee Z at his initial and subsequent visits on February 13, 2013

and March 13, 2013, respectively. Although Patient Q had no contact with Dr. Niazi at either of these visits, he signed prescriptions for Xanax brought to him by Employee X on both occasions. Employee X also offered to fill Patient Q's Clonidine prescription, which the patient declined since it was usually prescribed to him by his heart doctor. Moreover, when Patient Q specifically asked to see Dr. Niazi at his initial visit, Employee X explained that he was there for "maintenance, just to get [his] meds" and informed him that Dr. Niazi was booked up for the day and he would have to reschedule another appointment if he wanted to see him. Although Patient Q did see Dr. Niazi at a subsequent office visit on April 10, 2013, the patient reports that Dr. Niazi only spent four minutes with him and, during this short time, Employee Z came in and interrupted him for his signature on other patients' prescriptions three times.

x. Patient R, a 28-year-old female with bipolar disorder, states that, at her initial February 7, 2013 office visit, she was not seen by Dr. Niazi, but instead was seen only by an unlicensed employee (name not specified), who provided her a Xanax prescription signed by Dr. Niazi.

3. Dr. Niazi violated Sections 54.1-2914.A, 54.1-2915.A(3), (13), (16), and (17), 54.1-3302, and 54.1-3304.1 of the Code in that, during 2011-2012, he maintained, in an unlocked desk drawer in his office, controlled substances that had been dispensed by pharmacies to patients and then returned by patients to him, which he then re-dispensed in small brown envelopes to other

patients (including Ativan (Schedule IV) re-dispensed to Employee/Patient S), in violation of Section 54.1-3411.1 of the Code.

4. Dr. Niazi violated Sections 54.1-2915.A(3), (13), and (16) of the Code in that, during 2011-2012, he maintained and administered injectible liquid controlled substances in an unsafe and dangerous manner. Specifically, patients would return injectible medications prescribed by Dr. Niazi to him for storage in his unlocked desk drawer, which he would then administer intramuscularly to patients when they returned for regular office visits. Further, on or about March 1, 2012, an Investigator observed that Dr. Niazi had stored in his desk drawer two open vials of fluphenazine decanoate 25 mg/ml 5 ml, two open vials and two sealed vials of haloperidol decanoate 50 mg/ml 5 ml, one open vial of haloperidol decanoate 100 mg/ml 5 ml, and two 1 ml ampoules of haloperidol 100 mg/ml, none of which had any patient names, labeling, or other identifying information on them, making it impossible to determine and keep track of the ownership of medications and increasing the risk of administering the wrong medications to patients.

5. Dr. Niazi violated Sections 54.1-2915.A(3), (12), (13), (16), (17), and (18) and 54.1-3303.A and 54.1-3408.A of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, with respect to his care and treatment of Patients A, B, C, D, and G from approximately 2009 to 2012, in that:

a. Dr. Niazi failed to take or document an adequate history or to perform an adequate work-up to formulate his diagnosis of ADHD for Patient A, a 46-year-old female, on or

about April 20, 2011; hence, Dr. Niazi's prescription of Adderall (Schedule II) to Patient A on that date and over the course of the next year was not medically indicated.

b. Dr. Niazi failed to take or document an adequate history or to perform an adequate work-up to formulate his diagnosis of ADHD for Patient B, a 33-year-old male, on or about March 30, 2011; hence, Dr. Niazi's prescription of Adderall to Patient B on that date and over the course of the next year was not medically indicated.

c. Regarding Patient C:

i. Dr. Niazi regularly prescribed Lortab (Schedule III) to Patient C, a 32-year-old female, from approximately March 2010 until August 2011 (when she died from a drug overdose), without diagnosing or documenting a medical condition warranting such medication or performing any physical examination or evaluation during the entire treatment period. Although some progress notes document Patient C's self-report of migraine headaches and back pain, Dr. Niazi never performed any diagnostic testing or studies to determine the etiology of such pain nor did he obtain other objective evidence relating to those conditions. Instead, Dr. Niazi documented (on or about March 22, 2010 and September 3, 2010) that he would prescribe Lortab to Patient C until she found another pain specialist, based on her unconfirmed report to Dr. Niazi that she had been unable to locate a new pain management physician to replace the one who had previously been prescribing her Lortab. However, Dr. Niazi failed to obtain any prior treatment records from said specialist to confirm Patient C's account or clarify the nature of her alleged pain condition. Further,

although there is no additional documentation in his record indicating Patient C attempted to find another pain physician, Dr. Niazi nevertheless continued to prescribe her narcotics for approximately a year and a half.

ii. Dr. Niazi initiated narcotics therapy for Patient C notwithstanding his knowledge of her long and extensive alcohol and substance abuse history and history of medication noncompliance, which Dr. Niazi documented at the patient's initial office visit on March 1, 2010. Further, Dr. Niazi failed to appropriately monitor and manage Patient C's usage of the narcotics and other controlled substances he prescribed her, i.e., Dr. Niazi had no pain management/controlled substance contract in place and did not perform any pill counts or urine drug screens or access the Prescription Monitoring Program ("PMP") to ensure compliance with his medication regimen.

iii. Dr. Niazi failed to note and appropriately respond to signs of drug-seeking or abusive behavior by Patient C, i.e., receipt of a complaint from a pharmacist regarding her medication usage (documented on or about June 10, 2010), and the patient's request for an early Lortab refill on or about June 2, 2011 based on her report that her nine-year-old son had flushed all her pain pills down the toilet.

d. At his first office visit on or about June 6, 2011, Dr. Niazi diagnosed Patient D, a three-year-old, with ADHD, despite the fact that such diagnosis was inappropriate and not medically indicated for a child of that age. Further, Dr. Niazi commenced prescribing Patient D Vyvanse (Schedule II) and Clonidine (Schedule VI) for ADHD on that date (and

continued to do so thereafter through at least February 2012), even though Vyvanse is not approved or recommended for children younger than six years of age and Clonidine is not approved or recommended for children at all. Subsequently, Dr. Niazi added Intuniv and Tenex (both Schedule VI) to Patient D's medication regimen for ADHD, even though Intuniv is not approved or recommended for children under six years of age and Tenex is not approved or recommended for children under 12 years of age.

e. On a continuous basis from approximately September 2010 to June 2011, Dr. Niazi prescribed oxycodone (Schedule II) in escalating quantities/doses to Patient G, an 18-year-old female, absent a diagnosis or documenting a medical condition warranting such medication. Moreover, although Dr. Niazi prescribed oxycodone to Patient G for almost ten months, he failed to perform any physical examination or evaluation during that entire period. Finally, Dr. Niazi made no attempt to monitor and manage her usage of this medication, via a pain management/controlled substance contract, pill counts, urine drug screens, or accessing the PMP, and took no appropriate responsive action (but instead continued to prescribe narcotics) when Patient G asked for early oxycodone prescriptions on multiple occasions.

6. Dr. Niazi violated Sections 54.1-2915.A(3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, with respect to his care and treatment of Patients E and H as follows:

a. At Patient E's office visit with Dr. Niazi on July 28, 2011, a week prior to the patient's suicide, he failed to record a mental status examination or to ask (or document asking)

Patient E about self-destructive or suicidal ideation, notwithstanding the fact that Dr. Niazi noted the patient was tapering off of methadone and had a history of prior suicide attempts.

b. During Dr. Niazi's treatment of Patient H for schizophrenia from approximately 2009 to January 2011, he failed to obtain or order (or document ordering) any baseline or follow-up laboratory tests, despite the fact that he was prescribing the patient Depakote and lithium, medications which require careful monitoring of laboratory levels/values. Likewise, Dr. Niazi failed to obtain or order (or document ordering) any CBC labwork for Patient H during this treatment interim even though he was prescribing him clozapine, a medication with potential side effects necessitating such lab work.

7. Dr. Niazi violated Sections 54.1-2915.A(1), (3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine General Regulations, in that he failed to manage and maintain accurate and complete patient records for Patients A-S. As set forth above, although progress notes in these patients' records have Dr. Niazi's name on them, many of them in fact were entered and authored by his employees, with no indication that such information had been entered by these employees, rather than Dr. Niazi. Moreover, Dr. Niazi's patient records are often repetitive, containing and carrying over the same "canned" boilerplate information from visit to visit, as well as numerous inconsistencies and contradictory information that cannot be reconciled and/or is not adequately explained. Examples of such inadequate, misleading, or incomplete documentation include the following:

a. In each of Patient A-H's medical records, it is documented at almost every office visit "[n]o medications are currently taken," when, in fact, they were prescribed multiple

medications prior to and at each visit and those prescribed medications were listed at the end of the note.

b. In an office note for April 20, 2011, the status of Patient A's diagnosed panic disorder (without agoraphobia) was changed from active to inactive with no documented explanation of why or how that condition had changed. Further, Dr. Niazi's September 21, 2011 office note for Patient A documented that the patient "was seen on an emergency basis due to sudden emotional changes as a result of loss of meds" but failed to note what these sudden emotional changes were.

c. In the case of Patient B:

i. The progress note for Patient B's first office visit on August 5, 2010 documented that the patient had symptoms of depressive disorder with chronic or daily episodes of depression, feelings of sadness, concentration difficulties and irritability associated with depression, and a sad affect most of the time, but recorded "[m]ood is entirely normal with no signs of depression" in the same note.

ii. Patient B's progress note for August 31, 2010 documented that the patient reported he had recently experienced a seizure and was taken to the hospital. However, there is no documentation of any further information regarding this seizure, and instead, the same medical history stating that Patient B had no seizure disorder is carried over in the office note for this and subsequent dates.

d. An office note for Patient C for August 12, 2011 documented that the patient described continued depressive symptoms, that her affect was sad, and continued her diagnosis of

bipolar 2, most recent episode depressed; however, at the same time it is documented that the patient's "[m]ood is entirely normal with no signs of depression or mood elevation."

e. In the case of Patient D:

i. On or about June 23, 2011 (and in multiple office notes thereafter), Dr. Niazi's record for Patient D, a three-year-old male, documented that he needed assistance or cues for self-care tasks and that his ability to do domestic tasks was impaired and required assistance. Similarly, it is repeatedly documented in Patient D's record that his "insight into illness is poor", which would be expected in a child this age.

ii. Although Dr. Niazi had regularly prescribed Patient D multiple psychotropic medications over the prior six months, "[n]o active medications" is documented in the patient's November 14, 2011 office note, without any explanation of the reason for this change in the treatment plan. Moreover, at Patient D's next office visit on December 16, 2011, Dr. Niazi documented that "[c]ompliance with medication is irregular. He no longer takes prescribed medication"; yet, this note documented continuation of the medications Dr. Niazi had previously prescribed to him before November 14, 2011 (i.e., Vyvanse, Clonidine, and Intuniv), again without any explanation recorded for this change in treatment plan.

f. At Patient E's initial visit on or about December 10, 2009 and subsequently in an office note for March 10, 2011, it is documented that the patient had a history of suicidal thoughts, but had never made an attempt. However, in that same line in each office visit note, it is

documented "[Patient E] has made suicidal attempts. He made a suicide attempt by asphyxiation."

g. In the case of Patient G, an 18-year-old female:

i. The progress note for Patient G's first office visit on June 18, 2010 documented that she had a good attention span and had "no signs of hyperactive or attentional difficulties", but nevertheless diagnosed her with ADHD, combined type, on that date and continued that diagnosis at multiple succeeding office visits.

ii. Patient G's office note for February 20, 2012 documented that the patient was having a rough time due to her mother being in jail and facing a long prison time and that she had to move in with her father. However, in that same note, it is documented that Patient G lived with her mother. Also, that note documented that Patient G had both "a good attention span" and "a short attention span."

h. At her first office visit on February 4, 2013, Dr. Niazi's note for Patient K documented a diagnosis of major depressive disorder, recurrent, moderate (active), and anxiety disorder and prescriptions for Xanax, trazodone, and fluoxetine, even though the following narrative is recorded in that same note: "[s]he specifically denies psychotic, depressive, and anxiety symptoms....[n]either depression nor mood elevation is evident....[t]here are no apparent signs of anxiety. " The next office visit note for February 26, 2013 carries over these same (or similar) inconsistent statements and diagnosis/medications.

i. A February 1, 2013 progress note for Patient L documented that the patient was seen on an emergency basis at the request of another physician whose license had been recently

suspended; however, the note specified that "[t]he documentation and completion of record may have been done at a later date after data was gathered", without indicating the actual date of the first office visit or the actual date of the late data entry.

j. Although Dr. Niazi's progress note for Patient P's initial visit on February 13, 2013 documented a diagnosis of Bipolar I and prescriptions for Xanax and Risperdal, Dr. Niazi documented that "Patient [P] reports no major problems and seems to be doing well with the [unspecified] medications....Mood is euthymic with no signs of depression or manic process...[t]here are no signs of anxiety." However, Patient P's progress note for March 21, 2013 states that the patient's "anxiety symptoms continue. Feelings of anxiety continue unchanged", even though the note for the previous visit had documented no signs of anxiety.

k. At Patient Q's first and subsequent office visits to Dr. Niazi's practice (on February 13, 2013 and March 13, 2013, respectively), a diagnosis of major depressive disorder, recurrent, moderate (active) was documented and he prescribed Xanax, amitriptyuline, Lexapro, and Invega; yet, in both notes Dr. Niazi documented "Patient reports no major problems and is doing well with [unspecified] medications", "[n]o psychiatric complaints are expressed and he specifically denies, psychotic, depressive, or anxiety symptoms", "[Patient Q's] mood is euthymic with no signs of depression or manic process", and "[Patient Q] denies any psychiatric problems or symptoms", with no mention that Patient Q was depressed or sad.

l. Although Dr. Niazi's documented in the progress note for Patient R's initial visit on February 11, 2013 that the patient reported having "trouble with anxiety and mood swings," diagnosed the patient with Bipolar, and prescribed her Xanax, elsewhere in the note Dr. Niazi

stated "All psychiatric symptoms are denied. She describes mood as euthymic and stable....She describes no anxiety....There are no signs of anxiety." Similarly, Dr. Niazi's March 14, 2013 progress note for Patient R again documents a Bipolar I diagnosis and Xanax prescription, while the content of the note states "[Patient R]'s behavior has been stable and uneventful and she denies any psychiatric problems or symptoms....Psychotic, depressive and anxiety symptoms are denied. Mood is euthymic with no signs of depression or elevation. No signs of anxiety are present."

8. Dr. Niazi violated Sections 54.1-2915.A(18) and 54.1-2523.2 of the Code in that he allowed and instructed his unlicensed staff to access patients' Prescription Monitoring Program reports, when, by statute, that program can only be accessed by individuals holding a healthcare license issued by the Department of Health Professions.

CONSENT

I, Saifullah K. Niazi, M.D., by affixing my signature hereto, acknowledge that:

1. I have been advised specifically to seek the advice of counsel prior to signing this document and am represented by Martin A. Donlan, Jr., Esquire;

2. I am fully aware that without my consent, no legal action can be taken against me, except pursuant to the Virginia Administrative Process Act, § 2.2-4000.A et seq. of the Code of Virginia;

3. I have the following rights, among others:

   a. The right to a formal hearing before the Board;

   b. The right to appear in person or by counsel, or other qualified representative

before the agency; and

c. The right to cross-examine witnesses against me.

4. I waive all rights to a formal hearing;

5. I neither admit nor deny the Findings of Fact and Conclusions of Law contained herein, but agree not to contest them or any sanction imposed hereunder in any future judicial or administrative proceedings where the Board is a party; and

6. I consent to the following order affecting my license to practice medicine and surgery in the Commonwealth of Virginia.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, and with the consent of the licensee, it is hereby ORDERED that the license of Dr. Saifullah K. Niazi to practice medicine and surgery in the Commonwealth of Virginia is hereby INDEFINITELY SUSPENDED for not less than THIRTY-SIX (36) MONTHS from August 29, 2013, the date of entry of the Board's Order of Summary Suspension in this matter.

Upon entry of this Order, the license of Saifullah K. Niazi, M.D., will be recorded as suspended and no longer current.

Further, within five (5) days of entry of this Consent Order, Dr. Niazi shall:

1. Return his current license to the Board office;

2. Update his Virginia Practitioner Profile regarding his primary practice address and any other appropriate section, with the exception of the Virginia Notices and Orders section;

3. Surrender his Drug Enforcement Administration ("DEA") certificate and DEA 222

Schedule II order forms to the DEA and provide a copy of this surrender notification to the Board;

4. Submit written notification to any and all drug wholesalers or pharmacies that he has ordered from, or had an account with for the past five (5) years, that he has surrendered his DEA license and request that the account be closed, a copy of which shall be provided to the Board; and

5. Properly dispose of all Schedule II-VI controlled substances, including physician's samples, remaining in the practice, as provided, in part, in Section 54.1-3417 of the Code.

Should Dr. Niazi seek reinstatement of his license, he shall be noticed to appear before the Board, in accordance with the Administrative Process Act. As petitioner, Dr. Niazi will have the burden of proving his fitness to practice medicine and surgery in the Commonwealth of Virginia in a safe and competent manner.

Pursuant to Section 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD:

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

4/2/14
ENTERED

SEEN AND AGREED TO:

S. K. Niazi

Saifullah K. Niazi, M.D.

COMMONWEALTH OF VIRGINIA
COUNTY/CITY OF Richmond, TO WIT:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this 28th day of March, 2014, by Saifullah K. Niazi, M.D.

Paulette M. Johnson

Notary Public

Registration Number: 322993

My commission expires: 7/31/14